

**KENTUCKY COMMISSION
ON
SERVICES AND SUPPORTS
FOR INDIVIDUALS WITH INTELLECTUAL
AND OTHER DEVELOPMENTAL DISABILITIES**

**June 21, 2012
Fair Oaks, 4th Floor
Frankfort, Kentucky**

MEMBERS PRESENT

Commissioner Stephen Hall	Harold Kleinert
Deputy Secretary Eric Friedlander	
Deputy Commissioner Betsy Dunnigan	
Deputy Commissioner Reina Diaz-Dempsey	
Pat Seybold	William Shaw
Cathy Edwards	Glenna Taylor
Clyde Lang	Steve Zaricki for Steve Hendricks
Patty Dempsey	Gwynn Royster
Cherri Lolley	Representative Carl Rollins
Representative Jimmie Lee	
Steve Shannon	Anne Montgomery
David Matheis	Linda Sandidge

MEMBERS ABSENT

Shannon G. Caldwell
Senator Tom Buford
Senator Julie Denton
Malkanthie McCormick, M.D.

OPENING REMARKS

Commissioner Hall opened the meeting by thanking members of the Commission for their attendance and participation.

REVIEW OF MINUTES

Minutes for March 22, 2011 meeting were approved with the following changes: add "consideration of self-employment". It was also noted that self-employment should be included in the discussions of the Community Integration subcommittee.

SUBCOMMITTEE REPORTS

- Community Integration:—Steve Shannon is serving as the Chair. The members are going to travel statewide to gather information about community integration: its meaning and practice.
- Health and Welfare: Dr. Malkanthie McCormick is the Chair. This group is extending invitations to 2 other people, Dr. Matt Holder, who made presentation at this HB 144 meeting, and a nutritionist from UK. The group will focus on 2 recommendations from NCI 2010 Report which are: Increase participation in physical activity and decrease overall percentage of psychotropic medication used.
- Participant Direction: Patty Dempsey and Cathy Edwards are Co-Chairs. The group is concerned that once a person is enrolled in CDO they are not made aware of all services available. Availability of transportation is a big issue as is flexibility within the program. The group plans to team up with different groups to address issues and gather input.

Discussion: Representative Lee stated that the Participant Direction subcommittee should start with those administering the program, the regional Community Mental Health Centers (CMHC) to ensure their understanding of the program. The CMHC is the first point of contact for Participant Directed Services (PDS). Comments were made about it taking up to 6 months for approval of budgets and plans. Steve Shannon stated complaints about the CMHC could be made to KARP and he would address them.

Special Olympics Healthy Athletes Program Presentation

Dr. Matt Holder, the Chairman of the Board for Special Olympics Kentucky, presented a PowerPoint on the health initiatives of Special Olympics. Last year, Special Olympics reached more than 6000 athletes and have more than 300 unified partners. The Healthy Athletes program screens over 1000 athletes, trains more than 100,000 healthcare professionals annually. Over 85,000 eyeglasses were distributed along with hearing aids, dental care, orthotics and other products provided through partnerships. Additional information is available at www.soky.org.

Presentation of Medicaid Proposed SCL Regulations

Commissioner Hall reported the emergency regulation process will not be used. He further stated that the Division participated in 63 forums across the state and the information obtained is reflected in the regulation.

Those attending the meeting were informed of the regulation review process. Once Cabinet staff review the regulation, it will be filed with the Legislative Review Committee (LRC) and they will send out notice of written and public comment opportunities.

Representative Rollins indicated he likes conflict free case management and that the case manager will not be tied to any other provider. He expressed concern about the decrease in rate for case management. Another member also expressed concern about the rate stating case managers would have to increase their caseloads. It was acknowledged that case managers are empowered to act in best interest of the people they support with the new waiver. There are

concerns about case managers working for more than one entity with a decrease in quality. Another concern is proximity of the case manager to person being supported and there was a proposal for an accessibility standard, possibly no more than 30 minutes away from person.

Committee members asked about the new assessment process involving the Supports Intensity Scale (SIS) and the Health Risk Screening Tool (HRST). It was explained that these tools are designed for people with an intellectual or developmental disability. They help with planning and the HRST has been shown to improve health of people in other states using it. The SIS is nationally recognized and identifies the support needs of the person. Administration of the SIS is currently done by state staff; this may change to a case management function when it can be administered in a conflict free manner.

In regard to rates, the waiver was designed to be budget neutral which explains why some rates were increased and others decreased.

A member asked if the SCL providers were involved in the development of the regulations and the answer was yes. Staff conducted listening tours across the state in 2008; Commissioner Hall has spoken with over 600 families; and joint meetings were held with DDID, DMS and representatives of HB 144 subcommittees. Eric Friedlander reported that he met with various entities as well.

In regard to background checks, a member asked if they will be required of all staff and the response was yes.

One Commission member asked if they could have 90 days to make comments prior to going through review process. It was explained that the legislative review process may take up to six (6) months from start to finish and there will be opportunity for significant comments and negotiations. Leadership understands the concern about the changes and transformation for people to have a life in the community.

Once the regulation is passed, each recipient of SCL will begin participation during their birth month.

There was a challenge to the revised staff training requirement for those employed through Participant Directed Services (PDS). The proposed regulation allows 6 months for completing of training but they understood it to be 1 year from discussions with leaders. There are also questions about how the employee will get paid while completing training since not providing a direct, billable service. PDS employees are required to complete 15 hours of training while employees of SCL providers are required to complete 25. Other concerns with PDS include how payment for the following requirements will be made: first aid, CPR training and background checks. Members were informed CMS allows this to come out of the participant's budget.

Members took issue with respite hours being cut. If there is an exceptional need a request can be made through the exceptional support protocol.

Members are pleased with shared living and that participants receiving residential services can now utilize participant direction for other services.

Commission was informed there will be a Request for Proposal (RFP) for the fiscal intermediary function.

After discussion, it was determined the term “customized employment” will be added to the definition of supported employment.

Commission members expressed concern about administrative burden of HRST due to requirement of RN or LPN to conduct the initial assessment. There is additional concern about requirement to conduct random drug screens of 25% of employees annually. It seemed to some members as if a supported employment plan will be required for each person regardless of their wants and needs.

PUBLIC COMMENTS

Comments:

- Increase the cap on available units for Clinical and Consultative Services prior to be being submitted for the next step in the approval process to ensure that this waiver addresses the most critical issues for individuals living in the community.

RESPONSE: *Annual unit limit has been increased to 160 from 120 to allow 40 additional units to complete a functional assessment. If additional units are required due to an individual experiencing challenging medical, psychiatric, or maladaptive behavioral issues, they can be requested through the Exceptional Support Protocol.*

- Decrease the two years of experience required for Positive Behavior Specialist.

RESPONSE: *Reduced to one year to match all other professional staff.*

- Reconsider reduction in Adult Day Training rate.

RESPONSE: *To move in the direction of a philosophical shift from congregate to integrated lives for people, this reduction allowed for a considerable increase in rates for Supported Employment and Community Access.*

- Consider same expectation for staff training whether traditional or participant directed.

RESPONSE: *Participant directed employees will have similar requirements for CPR and First Aid, and will also be required to complete a reduced amount of training in the College of Direct Supports by removing courses that are geared towards a traditional provider setting. This will ensure all staff are adequately trained while not placing an undue burden on participants who choose to direct their services.*

- MAP 95 process is taking too long.

RESPONSE: *In revised regulation, the requirement for three estimates has been removed and the MAP 95 process has been moved into the Plan of Care so that necessary purchases are authorized through the POC process.*

- Positive comment about drug testing requirement as many providers already do this. Some concern about the 25% annual requirement.

RESPONSE: *Reduced annual requirement to 5%*

- Concern that Day Training and Sheltered work is time limited.

RESPONSE: *Per CMS: “Waiver funding is not available for the provision of vocational services delivered in facility based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.” So we included the following:*

Career planning activities to develop experiential learning opportunities and career options consistent with the participant’s skills and interests that are:

- a) Person centered and designed to support employment related goals; and*
- b) Directly relate to personally chosen outcomes by the participant which are documented in the POC; and*
- c) Are time limited.*

- Add “appropriate” to section 7 (5)(a) under emergency criteria.

RESPONSE: *The following change has been made:*

(a) Emergency. The need shall be classified as emergency if an immediate service is needed as determined by any of the following if all other appropriate service options have been explored and exhausted:

- Concern about definition of “remote area”

RESPONSE: *Revised to read as follows:*

Provides evidence that there is a lack of a qualified provider within thirty (30) minutes of the participant’s residence;

PUBLIC COMMENT

- The PCC is only required to have a high school diploma. While some have suggested that an individual with a Bachelor’s Degree could be hired, the reimbursement rate of \$22/hr

does not allow compensating clinicians with the appropriate degree at a competitive rate. Therefore, it is more likely that most PCCs will be equivalent to a Direct Support Professional. We currently work with many DSPs to appropriately implement the strategies written into the Behavior Support Plan. Although we work with many of these DSPs for up to three hours each week, they often do not have the educational background to understand the technical nuances of the BSP, and continue to revert to their own beliefs and experience. It is unlikely that a high school educated PCC is going to be able to accurately describe the strategies, explain why they will work, and ultimately influence a high school educated DSP to work with clients differently. They have the same educational background.

RESPONSE: *PCC services are optional. If use of a PCC is not clinically, scientifically sound, the service should not be used. All supports including positive behavior supports and clinical supports are designed to be Person Centered which means some services work for some and not others The PCC was designed to free up more professional time if it is an appropriate use of the service.*

- The educational background of behavior specialist requires a Master's Degree and at least 1 year of experience to perform the assessment of behavior, write behavior support plans, and monitor implementation and effectiveness of BSPs. In the new regulation, the duties for training, monitoring, analyzing, and making recommendations are given to the high school educated PCC. Again, the PCC is not educationally or ethically qualified to perform these duties, nor can 7 years of college education be taught to the PCC with some additional training.

RESPONSE: *That is not the intent of this position. According to the website for the National Behavior Analyst Certification Board (www.bcba.com) The BCBA Board of Directors "has authorized the development of a new professional credentialing program for behavioral technicians, the front-line staff who implement behavior plans." DDID staff met with behavior specialists to create the person centered coach and this was the intention. As the National board completes their work on this new position we are interested in how that compares to the person centered coach.*

The new regulation, through Consultative Clinical and Therapeutic services, actually provides a payment mechanism for Positive Behavior Specialists to bill for training and on-site observation which is not currently billable.

- The new regulations require that the PCC be supervised by the Positive Behavior Support Clinician. Given the cap on hours (only 1.5 hours a month—see above), it is impossible to appropriately supervise the PCC, let alone have any additional units for consultation with the team. If the Positive Behavior Specialist supervised the PCC for just one hour a month, the Master's level clinician would have only ½ hour month for all

other duties including, reassessment, ongoing support needs, crisis assistance, graphing of data, and answering other tem questions. As behavior specialists, we often lead the team in many different areas including good roommate matches, medical procedures/desensitization, family visits/contact, staffing patterns, etc because we know the clients the best. There are many well qualified individuals on the team with Bachelor's degrees and more, but they still rely on our expertise in many decisions effecting the client's life and behavioral status.

RESPONSE: *The intent was not for the behavior specialist to bill for supervision of the PCC's overall job performance but to observe, monitor and provide technical assistance to the PCC in the delivery of appropriate services as outlined in the POC and to guide the work of the PCC as a part of the individual's team. With more involvement of clinicians in the person's team; payment for on- site training and monitoring; payment for BSP revision; and greater accountability, there should be a more significant impact of these services which translates to a need for less units for some people. An individual who's assessed needs suggest they require more supports can utilize the Exceptional Supports Protocol to request additional units of these services.*

PUBLIC COMMENT

- I love being a case manager and the rewards go far beyond my paycheck but for my state to devalue a service that I provide with professionalism, caring and pride does not feel very good.
- Responsibility is increasing under the new waiver not decreasing. Keep the rate as it is.

RESPONSE: *Case management services are the cornerstone for excellence in providing assurances that people in SCL services are safe, have choices, are respected, and enjoy living and working in their communities. In order to promote best practice in Kentucky, case managers are being provided enhanced training that includes more tools and assessments to enable the case manager to better identify and implement support strategies. Through ongoing continuing education, case managers are empowered to facilitate and guide the person centered team towards designing person focused plans that reflects choice, opportunity, and what is important to and for the person. The adjustment of the rates is to better align Kentucky's rates with the national median payment ranges of \$100-250.00 per month as reported by NASDDDS.*

PUBLIC COMMENT

- At the HB 144 Commission meeting when we were asked for comments, I expressed my concerns for limitation in providing personal assistance. On page 70 of the regs it states these services are available to a participant who lives in his or her own residence or in his or her family residence. We serve many participants who live in Staff Residences or with FHP's who need personal assistance while attending their Day Training, Community

Access or Supported Employment. This assistance is personalized for each individual we serve and our staff are skilled in providing this service. Although the Staff Residence or the FHP provides this at home we are called upon to do these services in our Day Training, Community Access and Supported Employment Services. I would prefer to have this regulation say that this service is not available in a Staff Residents or an FHP setting. This way we can be creative to allow a person to work, receive Community Access or attend a Day Training and receive the Personal Assistance needed to accomplish tasks that they normally would do for themselves if they did not have a disability.

RESPONSE: *-Personal care is a component of residential services which is provided for up to 24 hours a day. A provider of residential services may not expect additional reimbursement for personal care of a person for whom they provide residential services.*

Personal care is a component of day training services. A provider of day training services may not expect additional reimbursement to meet the personal care needs of a person they provide day training services for. A day training provider is expected to assist the person with their personal care needs.

Personal care is a component of community access services. A provider of community access services may not expect additional reimbursement to meet the personal care needs of a person they provide community access services for. A community access provider is expected to assist the person with their personal care needs.

Personal care is not a component of supported employment services. If a person receiving SE services is also in traditional residential services, the residential provider must make arrangements to assist the person with their personal care needs while the person is engaged in SE services. If the person receiving SE services is not in traditional residential services, the case manager, SE specialist and the person should arrange for personal assistance services to occur while the person is in SE services.

PUBLIC COMMENT

- How will new rates be implemented? At one time or as the person's POC is due?

RESPONSE: *There will be a transition period whereby the new rates will be implemented when the participant transitions to new services during their birth month.*

Who will the Financial Management Agency for PBS (formerly known as CDO) be?

RESPONSE: *Medicaid will post an RFP for the fiscal management function.*

- Page 37, of 907 KAR 1:145 regarding Smoke Free Environment: will this mean that we don't have smoking areas outside of the office, such as back porch, and no smoking in the parking lot like I have seen occur around hospitals in the last few years?

RESPONSE: *Section 3.3 Smoke Free Environment of the draft version of the 2012 Supports for Community Living Policy Manual specifically addresses the issue of a smoke free environment. Included in the manual is the expectation that the provider staff, volunteers, and subcontractors will abide by local laws and ordinances governing smoke free environments in those locations where said laws and ordinances exist. Additionally, SCL provider staff, volunteers, and subcontractors are expected to provide a smoke-free environment for any individual who chooses such. This would include settings in which the individual is expected to spend any amount of time such as a home, Day Training site, meeting site, or any other location.*

The intention of this policy is not to deny choice for individuals who choose to smoke. Rather, it is a safeguard and a means of protecting the rights of those who do not. Therefore, it is expected that SCL individuals will be carefully assessed to determine health needs and provided sufficient information to make fully informed choices about smoking and smoke-free environments and those choices will be documented and supported by SCL provider staff, volunteers, and subcontractors.

- Is the statement on page 40 of 907 KAR 1:145 a typo? The statement says.... “smoke detector placed in all bedrooms and other strategic locations.” I believe the statement was meant to read as smoke detector *placed in bedroom areas* and other strategic locations. Correct?

RESPONSE: *No. The wording in the regulation was meant to read as written.*

- On page 42 of KAR 1:145 it says.... “Annual basis provide or arrange for a minimum of six (6) clock hours of continuing education units of competency based training to each employee and subcontractor to teach and enhance skills related to their duties.”
 - Can this be training that is provided at the agency by agency staff? For example, in a usual year I normally do 2 hours of training per month on various topics, such as dementia, community participation, etc. during staff meetings. I use tapes, curriculums I gather and some I compose myself. I do a post test for some topics. It is not affordable or possible to send all staff to training out of agency.

RESPONSE: *Yes. An executive director may elect to provide on-site training utilizing staff with specific expertise in the subject matter being trained if the material is competency driven and staff can demonstrate, either through post-testing or observation, mastery of content.*

- Can this annual competency based training include FA, CPR and Medication Administration update?

RESPONSE: *Yes, as long as the provider of the training meets the requirements established in the regulation for those topics.*

- ST, OT, PT cannot get their license renewed unless they have their required continuing education units, shouldn't a copy of their license suffice for that proof?

RESPONSE: *Yes. The renewed license may be used as proof of meeting on-going professional development/continuing education requirements.*

- On page 43 of 907 KAR 1:145, DDID Crisis Prevention training, will any other curriculum be acceptable in place of this such as MANDT, CPI, etc?

RESPONSE: *No. If your staff has not received and passed the Train the Trainer of DDID Crisis Prevention training, you will be required to have one or more staff members attend and become eligible to serve as trainers for your agency utilizing DDID Crisis Prevention training materials.*

- Page 28, 907 KAR 1:145 – An SCL provider shall ensure that a non-participant directed SCL waiver services are not provided to a participant by a staff member of the SCL provider who has one of the following relationships to the participant:legal guardian....stepchild.
 - Issue: While I agree with this statement I do not want to see current relationships and homes destroyed because of it. We have many FHPs, some with the encouragement of our state guardianship services, have become the guardian for folks in their home. These are long lasting relationships. I also have a FHP where the individual she provides services to is technically her stepchild even though she has not been married to the father of the individual for over 30 years.

RESPONSE: *The long-standing FHP relationships will be reviewed on a case-by-case basis and a determination made regarding the relationship, the desires of the participant, and the impact upon the participant's quality of life should changes in providers of support services be made.*

- Page 29, 907 KAR 1:145 – Document any denial for a service and reason for denial and identify resources necessary to successfully support participant in the community.
 - Issue: I receive referrals by mail, by fax and by email daily. Some days there are multiple referrals. For many of these, my agency is not the only agency receiving the material and the individuals may or may not want to relocate to my particular area. Please consider removing the requirement to *identify resources to successfully support participants in the community.*

RESPONSE: *The clause “and identify resources necessary to successfully support the denied participant in the community” has been removed.*

- Page 36, 907 KAR 1:145 – TB Skin Test
 - Issue: Providers often obtain TB skin tests for everyone throughout local Health Departments. In most of our Health Departments they will not even schedule a date for a screening/test until one week prior to their last TB screening/test and will not actually do the test/screening until after one year date of the last test/screening. Please consider giving providers at least a 30-day leeway from the date of the last TB test/screening to get the new test/screening completed for each employee.

RESPONSE: *The regulation was amended to read as follows: “Complete tuberculosis (TB) risk assessment performed by a licensed medical professional and, if indicated, a TB skin test with a negative result within the past twelve (12) months as documented on test results received by the provider within thirty (30) days of the date of hire or date the individual began serving as a volunteer.”*

- Page 43, 907 KAR 1:145 – Consider the elimination of the need to require subcontractors who are licensed professionals and each family member in a residential Level II family home from having to complete the full training requirements of case managers and employees related to CDS modules, DDID Crisis Prevention and Intervention, and First Aid / CPR.

RESPONSE: *The regulation was amended to read as follows:*

“(e) Ensure that all case managers and employees, prior to independent functioning, successfully completes training which shall include:

- 1. First aid, which shall be provided by a certified trainer with a nationally-accredited organization to include the American Red Cross and the American Heart Association and evidenced by official documentation of completion from the nationally-accredited organization;*
- 2. Cardiopulmonary resuscitation which shall be provided by a certified trainer with a nationally-accredited organization to include the American Red Cross and the American Heart Association and evidenced by official documentation of completion from the nationally-accredited organization;*
- 3. Department of Behavioral Health, Developmental and Intellectual Disabilities’ Crisis Prevention and Intervention Training;*
- 4. Successful completion of all Kentucky College of Direct Support Phase I training modules; and*
- 5. Individualized instruction about the person centered POC of the participant to whom the trainee provides supports; and*

6. Verification of trainee competency as demonstrated by pre- and post-training assessments, competency checklists, and post-training observations or evaluations.

(f) Ensure that all case managers and employees, unless the employee is a licensed professional providing services governed by the licensure of their profession, complete Kentucky College of Direct Support Phase II training modules, no later than six (6) months from the date of employment or when the individual began providing services.”

The following addition was made:

“(i) Ensure that each adult family member residing in a level II residential foster care or family home provider who may be left alone with the participant will receive training on the individualized needs of the participant from the case manager.”

- Page 59 – 907 KAR 1:145 – Day training only for participants at least 21 years old
 - Issue: We work with local school districts to transition students during the last years of their secondary education. This has been very helpful to individuals and to families. This not only gives us an opportunity to work with individuals to transition to day program, it also gives an opportunity to get to know the individual and also continue school to work situations. There are also many families and individuals who desire to leave special education services at age 18.
 - Please consider the addition of this statement: *“Be provided to participants age sixteen (16) to twenty-one (21) as a transition process from school to work or adult support services.”*

RESPONSE: *The clause in question refers to only Adult Day Health Care Day Training. No changes have been made.*

- Page 75 – 907 KAR 1:145 – Technology Assisted Level I Residential
 - Issue: This service would be most effective for individuals who live in their own home. Our agency supports two (2) SCL individuals who could greatly benefit from this type of assistance. Please consider making this available to individuals who live independently.

RESPONSE: *The individuals referenced in the above situation could purchase appropriate technology utilizing Goods and Services.*

- 907 KAR 1:145 – Progress Notes – Requirements specifically outlined in Day Training and Residential Services.
 - Issue: Please eliminate the need for daily notes. This will become nothing but an administrative burden. Have just a monthly summary for residential or maybe a checklist of activities based on the POC to mark each day and then have a Monthly Summary.

RESPONSE: *No changes were made to the requirement of daily notes.*

- Page 5 – Supports for Community Living Policy Manual.
 - Issue: All members expected to attend POC unless extenuating circumstances. Contracted therapists are not compensated for time spent in POC meetings and attendance may not always be possible if they serve more than one SCL agency. Please consider receiving input from the contracted therapists in other ways such as conference call, written notes, etc.

RESPONSE: *The clause has been amended to read as follows:*

“All Team members are expected to participate unless extenuating circumstances prohibit their face-to-face involvement.

- References found throughout the Regulation regarding the Health Risk Screening Tool (HRST)
 - Issue: In order for the initial HRST to be completed, as it should and by the nurse, it is going to take considerable time and is going to be very expensive. Consider reimbursing the cost of the initial training.

RESPONSE: *No plans are being made for reimbursement of the initial or ongoing training requirements for the HRST; the regulation does include an increase in residential rates to offset some of this cost.*

- Page 4, 907 KAR 1:155 – ADT Rate Reimbursement
 - Issue: Decreasing the rate is going to have a huge effect on day programs. Providers need time to build up supported employment services across the state. Don't decrease the current ADT rate until providers have had an opportunity to just that. Day programs have a valued place in our current service system. Many individuals have jobs but most of those are part time jobs. Day program is still where individuals spend the majority of their time. Providers also have a large retirement age populations. Let's make this time quality time while we work together to build job opportunities and more community opportunities for individuals who desire it.

RESPONSE: *Rates for Day Training are not being considered to be increased. Community Access and Supported Employment rates will cover the need to move individuals from a Day Training environment to true person centered participation in their communities.*

- The members of the Commonwealth Council on Developmental Disabilities are excited about the drafts of 907 KAR 1:145 and 907 KAR 1:155 released on 6-14-12. At the time of submission of these comments, our members continue to discuss our stance and suggestions on some of the specifics; we will submit more detailed comments prior to the

public hearing on the version of the regulations that are submitted to the LRC. Overall we think these draft regulations are conducive to greater independence, inclusion and choice for the individuals served, and we applaud the Department for Behavioral Health, Developmental and Intellectual Disabilities for advancing the SCL regulations in this direction.

Meeting Adjourned